

DEC 14 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

40624

1. PLACE OF DEATH

County BollingerRegistration District No. 67Township ScopusPrimary Registration District No. 5766

City

(No.)

St.

Ward)

2. FULL NAME John Anderson Walker(a) Residence, No. Near Scopus, Mo.

St.

Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)Married5A. IF MARRIED, WIDOWED, OR DIVORCED,
HUSBAND OF Ada E. Walker
(OR) WIFE OF6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 8, 1886

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.81724

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.Farmer9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Deary, Mo.

FATHER

13. NAME Mrs Ben Walker14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)U.S.A.

MOTHER

15. MAIDEN NAME Jane Clay16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)U.S.A.17. INFORMANT
(ADDRESS)Silva Walker
Millersville, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Fairview Cem. Millersville, Mo. DATE Oct. 4, 193719. UNDERTAKER
(ADDRESS)Edw. H. Baker
Rt. 1, Box 10, Gies
J. J. Chaudhry20. FILED 2/1

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 2, 1937

22. I HEREBY CERTIFY, That I attended deceased from

Jan 1st, 1936 to Oct 2nd, 1937I last saw him alive on Sept 1st, 1937 Death is saidto have occurred on the date stated above, at 1:00 A.

The principal cause of death and related causes of importance were as follows:

Paralysis

Date of onset

Other contributory causes of importance:

Senility

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Edw. H. Baker

M. D.

(Address) Edw. H. BakerEdw. H. Baker

828

.....
Wp
Ac
Wp
.....
Wp

ВАНТА

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

40624
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1. PLACE OF DEATH

(a) County Bollinger Registration District No. 67
(b) Township Sharp Primary Registration District No. 5106 Registered No.
(c) City (d) Street No.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

John Anderson Welker
(a) Residence, No. St. ☐ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 7 24

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 2 1937

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

I last saw h. alive 19..... Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

paratyphoid agutans
175
Date of onset

Other contributory causes of importance:

remedy

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Edw. Crites M. D.

(Address) Bedfordville Mo

